Training peers to ease hospital discharge: A community-clinical partnership in complex HIV care

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Abstract

Background: As many people now live with HIV as a complex, chronic health condition that may require frequent medical and psychosocial services, a potential new role for HIV-positive peers involves support during an inpatient admission that extends past discharge to improve the transition home from hospital.

Objective: To begin outlining scope of peer support in complex HIV care, this article details a training curriculum alongside experiences and recommendations by Peer Volunteers.

Methods: A community-clinical partnership designed a personalized peer intervention for people living with HIV who were acutely hospitalized and struggling with antiretroviral adherence and substance use. Five Peer Volunteers delivered the program, which involved being matched with a participant for a pre-discharge in-person meeting followed by frequent phone contact in the seven weeks following discharge. A four-day peer training focused on active listening, structuring a call, use of self, boundaries, and facilitating program closure. The curriculum was informed by theories of change, motivational interviewing, and simulation. Peer Volunteers participated in pre-match and post-match interviews with peer researchers (also living with HIV). Thematic analysis was employed by four independent coders to understand how prepared peers were and areas for program improvement.

Conclusions: Peers verified participant feelings and affirm their experiences, followed-up on participant goals to track progress, disclosed their own relevant experiences to build rapport, and facilitated closure to enable program success. Peers struggled maintaining an emotional connection over the phone and were concerned when participants were nonresponsive. This article discusses how the training was piloted and adapted for practice.

Keywords

Peer support; training; volunteers; qualitative research; community participation; delivery of health care; HIV/AIDS

I. Introduction

Peer support has been a fundamental component of the HIV/AIDS response since the epidemic's onset[1,2]. Peers, who share identities with people accessing social services, have designed and delivered programs across the HIV prevention[3], treatment[4], and care[5,6] cascade. As many people now live with HIV as a chronic health condition that may precipitate and/or exacerbate complex health and psychosocial issues[7,8], potential new roles for peers have emerged. One such role involves the connection of clinical and community-based services via peer support that starts during an inpatient admission and extends past discharge to improve the transition home from hospital[9,10].

In this paper, we define complex health as numerous medical (e.g., polypharmacy, cancer, hepatitis C, mood disorders, neurocognitive challenges) and psychosocial (e.g., substance use, homelessness, unemployment, food insecurity) challenges that can result in poor health, frequent hospitalizations, and barriers to care[11]. Peer support can improve access to HIV prevention[12] and care[13], however peer models for complex HIV healthcare are still in development.

Nations worldwide have made ambitious goals for changing the trajectory of the HIV epidemic, and ending HIV/AIDS. Peer programs and peer support have been recognized as an important component of an HIV strategy; it is recognized in the United Nations Political Declaration on Ending AIDS with a commitment of increasing the proportion of services that are community-led to at least 30% by 2030[14]. There is increasing evidence supporting the potential benefits of peer support for both clients[2] and peers[15,16], but in order to facilitate scale-up there is a need for peer support models to be described in greater detail[15]. There have also been calls for standardized and accredited training for peers in both HIV[17,18] and mental healthcare[19]. With this paper we are sharing, in detail, our peer training curriculum, and experiences and perspectives of our Peer Volunteers, to contribute to an open dialogue about the resources necessary to support peer programs and to assist others in the tailoring and implementation of peer programs. Primary intervention results of our peer program's pilot study, focused on antiretroviral (ART) adherence and substance use, are described elsewhere[9].

I.A Objective

This article presents a four-day, twenty-two hour Peer Volunteer training curriculum followed by lessons learned from the experiences of the Peer Volunteers who delivered a three-stage, personalized intervention designed to support people living with HIV and complex needs through the transition of discharge from hospital.

I.B Partnership Description

In early 2016, Casey House, a hospital for people living with HIV, approached the AIDS Committee of Toronto (ACT), a community-based HIV organization (CBHO) to design and pilot a peer support program for to ease discharge from hospital's inpatient program, based on priority areas of medication adherence and substance use identified by people accessing the hospital. The two organizations had collaborated on numerous initiatives in the past (such as coordinated access to care). Partners included a team of five Peer Volunteers to deliver the program, five Peer Researchers to assess the program, and agency staff, including two with academic affiliations. Alongside organizational history of collaboration, members of this partnership also collaborate for improved services regarding HIV, aging, and cognition[20-22]. A formal partnership agreement (supplementary file 1) detailed partner roles and responsibilities. The pilot program ran from 1 April 2017 to 31 March 2018, and the team has since launched peer support at the hospital as an ongoing program. This article is written from the perspective of the partnership's primary peer, community, and academic partners with agreement from the full team.

II. Methods

This personalized peer intervention (titled *The ART of Conversation*) was developed through extensive consultation with people living with HIV, as a partnership between a CBHO and a hospital for people living with HIV. This training curriculum was evaluated through longitudinal interviews with Peer Volunteers (n=5) about their experiences and recommendations as they provided service in the pilot peer program. Ethics approval was obtained from the University of Toronto's HIV/AIDS Research Ethics Board (Protocol ID# 34124).

II.A. Participants

Five Peer Volunteers were recruited by the first author from his direct service work at ACT. Requirements to be a Peer Volunteer in this intervention were self-identifying as living with HIV, on ART with past adherence challenges, and a history of substance use.

II.B. Intervention

Peer Volunteers delivered two components of the three-stage intervention for people living with HIV who: a) were inpatient at the hospital between 1 April 2017 and 31 March 2018; b) had challenges with ART adherence; and c) self-identified substance use. See Figure 1 for the intervention's description. The hospital's inpatient clinical team recruited participants by ascertaining preliminary interest and referring participants to the first author. Participants met with the first author to confirm eligibility, provide consent, and discuss intervention details. This included being matched with a Peer Volunteer, which was primarily based on availability and occasionally on shared demographics (such as gender) if it would facilitate a more comfortable match. The participant then set adherence, substance use, and an open-ended goal (most commonly, housing and social connection) with an inpatient nurse, and met their Peer Volunteer to discuss their goals alongside plans and supports for their upcoming hospital discharge. Peer Volunteers phoned participants for seven weeks following discharge (once per day for the first three days, then once per week for the remaining six weeks). Fifteen volunteer-participant matches were initiated; each Peer Volunteer worked with two to four participants.

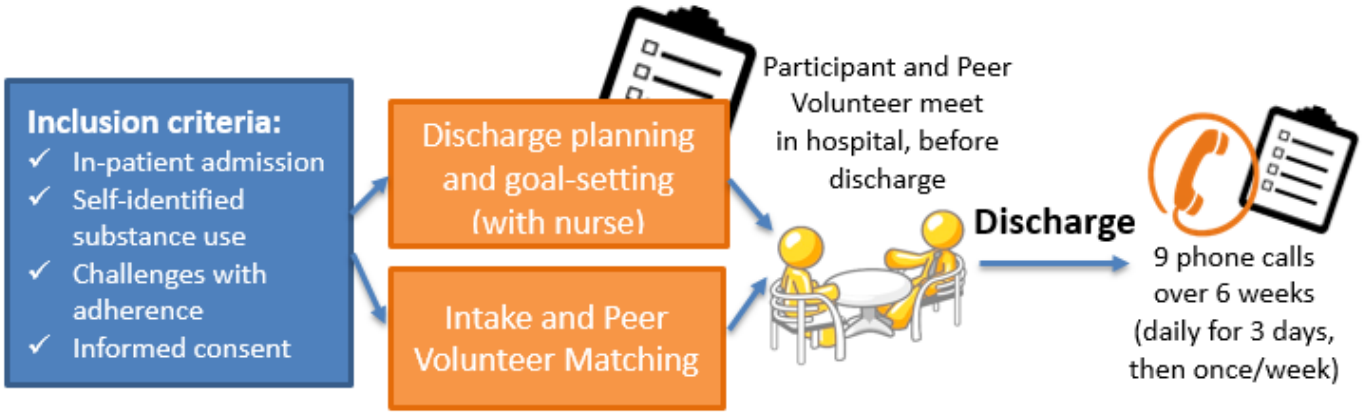

Figure 1: Intervention description

II.C. Training Curriculum

To register as volunteers with ACT, all participants had already completed twenty-two hours of core training focused on basics of HIV and health promotion, communication, anti-oppression, and creating safe and accessible spaces. For *The ART of Conversation*, an additional four-day, twenty-two hour training was designed and facilitated by the first and fifth author (both social workers) to prepare Peer Volunteers for this specific role.

The training curriculum (Table 1) focused on processes of communication (e.g., active listening, empathy, use of self) and content relevant to the peer program (e.g., substance use, harm reduction, hospitalization) and was developed through collaborative meetings of the partnership team and consultation with people who could potentially access the program. This involved client engagement sessions at Casey House where the clients prioritized support for ART adherence and substance use, recommended a harm reduction approach[9], and gave recommendations that Peer Volunteers should be trained to be good listeners and able to provide referrals to other services. The partnership team's people living with HIV had extensive experience with peer support and human service, and identified the Satir Change Model as the framework for training[23]. This model considers how an individual's desired behavioural change goes through resistance and chaos first, and that support from a service provider can be a catalyst in improving the change's potential for integration and ultimately becoming the new status quo[23]. Training concepts were further refined using the principles of motivational interviewing, which shifts away from giving advice and towards a discussion of positive and negative consequences to change[24]. The partnership's agency staff representatives suggested motivational interviewing, which attempts to help people find motivation to make positive decisions and accomplish their goals, as the approach to offer support within the Satir framework, due to its theoretical alignment and effectiveness in supporting people who use drugs[25]. Simulation (i.e., role-play exercises) was the third major component of the training curriculum. Practicing skills has been identified as the most helpful aspect of peer training when compared with lecture or discussion[22,26]. The simulation scenarios were developed by the training facilitators based on their combined twenty years of experience in community-based HIV service, with input from client consultation sessions and the larger partnership team.

Table 1

Peer volunteer training curriculum

Day one – three hours		
Activity	**Description**	**Timing**
Introduction/ice breaker		20 minutes
Norms and guidelines	Discuss program ground rules (e.g., confidentiality, respect for difference) and simulation guidelines (e.g., feedback)	10 minutes
Congruent communication	Consider how to incorporate the self, other, and context into communication	20 minutes
	Break - 15 minutes	
Empathy & active listening	Define empathy and discuss verbal (e.g., paraphrasing, summarizing) and non-verbal (e.g., posture) active listening skills	30 minutes
How to structure a call, part 1: How to give good phone	Discuss how to have a productive phone conversation, including how to work with silence, ask for understanding, changing topics, statements that may help a participant talk	30 minutes
Simulation	Scenario 1: Participant wants to engage in social activities but feels isolated. Participant will segue into tangents, volunteer needs to keep conversation focused.	45 minutes
Check-out	Share learnings and opportunities for day two	10 minutes
Day two – eight hours		
Check-in and toolbox review	Review skills covered in day one	20 minutes
Introduction to substance use	Examine the history, pharmacology, and effects of substances; discuss how substances are used and the associated equipment	1.5 hours
	Break - 15 minutes	
Drug use stigma	Consider biases regarding substance use; societal norms and messages; how to challenge drug use stigma for ourselves and our clients	1.5 hours
	Lunch - 1 hour	
Harm reduction	Learn harm reduction strategies; examine behaviours associated with drug use; consider process and supports that are important for change	1.5 hours
	Break - 15 minutes	
Initial peer meeting	Discuss the in-person meeting with participants in hospital, including how to cover goals and plan discharge transition	30 minutes
Simulation	Scenario 2: Peer meeting where participant wants to adhere to ART but has challenges when using drugs, wants to try swallowing substances instead of injection.	1 hour
Check-out	Share learnings and opportunities for day three	10 minutes
Day 3 – three hours		
Check-in and toolbox review	Review skills covered thus far	20 minutes
Supporting decision-making	Learn how to use motivational interviewing to assess pros and cons of a potential decision instead of giving advice	30 minutes
How to structure a call, part 2: Call agenda	Discuss call components: check-in, summary and agenda-setting, establish time parameters, discussion, check-out.	30 minutes
Simulation	Scenario 3: Participant wants to discuss pessimistic feelings about ART adherence	30 minutes

	Break - 15 minutes	
Use of self	Consider the benefits (strengthening relationship) and challenges (shifts focus away from participant) of self-disclosure	20 minutes
Simulation	Scenario 4: Participant asks numerous questions about Peer Volunteer's history with substance use	25 minutes
Check-out	Share learnings and opportunities for day four	10 minutes
	Day four – eight hours	
Check-in and toolbox review	Review skills covered thus far	20 minutes
Boundaries & challenges	Discuss how to maintain appropriate boundaries with participants and strategies for crises (e.g., referral to other supports)	30 minutes
Simulation	Scenario 5: Participant is feeling suicidal, Peer Volunteer conducts brief assessment and refers to crisis services	1 hour
	Break - 15 minutes	
Closure	Discuss time-limited nature of intervention, how to end the program without the participant feeling that they have lost a key service	30 minutes
Simulation	Scenario 6: Participant is glorifying substance use, volunteer redirects to their goal of reduced use Scenario 7: Participant is despondent about their health, no longer sees purpose in adhering to ART	1 hour
Self care	Discuss self care strategies and how to access supervision and support during the program	30 minutes
	Lunch - 1 hour	
Program logistics	Discuss logistics of meetings, timing of phone calls, reporting, etc.	35 minutes
Simulation	Repeat earlier simulations now that all training concepts have been covered	2 hours
Check-out and wrap-up	Review training and share lingering concerns that can be addressed through further support	20 minutes

Simulation was assessed using the tool in Table 2, adapted from a framework to assess simulation in social work education[27]. The assessment skills aligned with those discussed in the training, and Peer Volunteers received these assessments and a verbal summary from the training facilitators.

Table 2

Simulation assessment tool

Concept	Description	Assessment method
	Active listening	
'Door opening'	Open-ended questions to invite participant to elaborate	Behaviour counts, comments
Encouraging	Show genuine interest, keep participant talking	
Reflecting	Identify participant's emotions	
Paraphrasing	Show that you have understood; check-in to see if correct	
Clarifying	Ask closed-end questions to ensure understanding	
Summarizing	Review what has been discussed so far	
Affirming	Validate participant's views and experiences	
	Call agenda	
Check-in	Follow-up on how participant has been doing since last call, issues to discuss today	Score out of five, comments
Agenda-setting	Confirm agenda for today's call	
Session content	Quality of conversation, use of communication tools	
Keeping time	Staying within established parameters	
Referrals and follow-up	Connection to other services; follow-up on previous referrals	
Check-out	Summarize conversation, ask for feedback	

II.D. Data Collection

For each participant match, a Peer Volunteer participated in semi-structured interviews at two times: immediately following the in-person peer meeting, and at the conclusion of post-discharge telephone support (seven weeks after discharge). Interviews were conducted by a Peer Researcher living with HIV, were audio recorded, transcribed verbatim, and averaged 00:21:52 in length. The interview questionnaires contained the following topic areas: a) Goals & Expectations; b) Intervention Experience; c) Intervention Impact; and d) Participation in the Research Study. Examples of questions were: a) "What was especially helpful for your interactions with the participant, from the Peer Volunteer training that you received?"; b) "How could you have been better prepared for interacting with the participant?"; and c) "How supported have you felt in your Peer Volunteer role?". The Peer Researchers were distinct from the Peer Volunteers and, aside from these interviews, had no study-related contact with the Peer Volunteers. Participants received $30 Canadian honorarium for attending interviews.

II.E. Data Analysis

Thematic analysis was chosen to interpret the qualitative data due to the method's flexibility to consider diverse perspectives[28], as the Peer Volunteers varied in age and other demographics (e.g., length of HIV diagnosis) and had matches of varying levels of engagement. A team of four coders independently read the transcripts and then conducted line-by-line coding by for how peers demonstrated skills from training improvement areas. These two themes were identified a priori, based on the team's prior experience with training peers[22] and present objective of understanding experiences of Peer Volunteers in this pilot. Fifteen transcripts were assigned per coder, with each transcript coded twice, and Microsoft Excel was used to organize the data. The coding team then met for three hours to discuss their independent findings and achieve consensus on the themes presented below, which focus on the post-match interviews as Peer Volunteers tended to provide more detail on program strengths and challenges after engaging with participants. Achieving consensus in this single meeting may have been facilitated by the team's many years of partnership and close involvement with this study.

III. Results

Four of the Peer Volunteers are gay Caucasian men and one is a heterosexual Caribbean woman. Their average age was 44 years (range: 28 to 60). Results are themed around Demonstrating Skills and Improvement Areas. Each quote is accompanied by a unique identifier (V1-5) and whether it was the Peer Volunteer's first, second, third, or fourth match with a client in the program. With a small sample, other demographics have been excluded to protect the anonymity of Peer Volunteers.

III.A. Theme 1: Demonstrating Skills

Peer Volunteers regularly demonstrated using skills that were taught in training. One volunteer reflected that "…everything that I learnt in the training prepared me, especially how to steer conversations back to the topic at hand" (V2, fourth match). Refer to Table 3 for five quotes that reflect the demonstration of specific skills (i.e., active listening, goal follow-up, use of self, boundaries, and closure) taught in training. Peers found system navigation and providing referrals to be a strength of their role, as they would work with clients to identify appropriate supports beyond the scope of the peer program. Boundary negotiation was the skills that Peer Volunteers most frequently identified

demonstrating in practice and wanting to improve, as some felt uncomfortable determining a set time to engage with their client and waiting an appropriate amount of time for clients to return their call.

Table 3

Participant quotes regarding specific skills

Skill	Quote
Active listening	The [participant] has used drugs for a long time and has cognitive impairment, so he's not always coherent and speaks very fast, quickly moving from one topic to another. From training, I've used a lot of active listening by trying to verify what he's saying. So we made a plan that he'd write down what he wants to talk about ahead of the call and we'd clearly set an agenda at the outset. (V3, second match)
Follow-up on goals	I was prepared. I read over [the participant's] goals. In my opinion, I think they're achievable for him. I came in with a pill box for him [to organize] his day and night medications because that was one of his issues. He was grateful for that. (V1, second match)
Use of self	The [participant] doesn't know anyone who's overcome substance use, so we discussed my own addictions. I've been addiction for 17 years to drugs, narcotics and stuff. I let him know that I've been sober almost six years, so it is possible. That seemed to help him open up a little more. (V3, first match)
Boundaries	I realized I've seen the [participant], I think he lives in my building. But I have to keep my own boundaries. Even though he's in my building, the support is a phone call and referral to other services. So when we talked about the state of his apartment, I said 'You could contact a case worker to come over and have a look at it'. (V3, third match)
Closure	I [regularly] let the person know that the program does end. That by the end of the program, I really want to make sure that they're set on where they want to be. (V4, fourth match)

III.B. Theme 2: Improvement Areas

Overall, peers appeared satisfied with the training. However, in post-match interviews they reflected that the training could have better prepared them for some of the program's realities. Specifically, Peer Volunteers were occasionally unsure of how to discuss their own history with substance use in peer support. Communication between hospital staff and Peer Volunteers was also identified as an improvement area. A nurse would set discharge goals with a client, for them to then discuss and refine in meeting their Peer Volunteer, and a volunteer noted that:

> When the goal forms are more thoughtfully filled out, it saves time and stops the person from having to say it again if they're shy and it's easier for me to lead when I have a written form of what their goals are. (V2, third match)

Another challenge in transition from nurse goal-setting to peer meeting was that clients would often communicate differently with a clinician compared to their peer. One example is that clients would set abstinence-based substance use goals with the nurse, then change their substance goal to a harm reduction focus when meeting their peer. As a volunteer said, "The [participant] doesn't want to quit drugs, despite what's on the goal form. She's more in a harm reduction phase, which I can work with but it would have been good to know that going into the meeting" (V4, second match).

The training framed post-discharge phone calls as similar to a unit of in-person service provision, which may last up to an hour, yet "the longest of my calls was eight minutes" (V4, first match). However, peers expressed that the training's simulations "…could do more around connecting with the person" (V1, third match). Overall, Peer Volunteers found phone engagement challenging and stated that in-person peer support, or a combination approach, would be easier for maintaining contact and understanding how they help participants. Phone support may also put too great an onus on relational dynamics, as one volunteer says "overall it was great as [participant] has been the most upbeat and optimistic person I've been matched with, which made a considerable difference in our phone calls" (V5, third match).

IV. Discussion

This study responds to a call for training curriculum to prepare peers for HIV support services, especially concerning substance use[27]. The combination of change processes, motivational interviewing, and simulation[23,24,26] appeared to prepare Peer Volunteers to support participants living with HIV and complex needs. In interviews, participants recollected training components that involved active practice through simulation (such as active listening and maintaining boundaries) and did not explicitly mention training components that were more didactic in learning presentation (such as an introduction to substance use). This suggests that active learning strategies, where participants can apply knowledge in simulation, may prepare peers better than more passive strategies such as lectures[22]. The training's simulations could have been further enhanced by the use of film, where trainees can watch themselves in role-play and adapt their performance accordingly[28]. Such an activity has been identified as mitigating the power imbalance between trainer and trainee, as trainees can assess their own performance[26]. This study corroborates existing literature that shows peers can have a key role in improving care access in HIV[2,5] while adding that complex HIV

healthcare is also an area that peers can provide service. While this study addressed prior studies' concerns of inadequate training and support[29,31], Peer Volunteers could have been better prepared for disclosing their substance use history and negotiating boundaries[32]. Overall, matches progressed more easily when communication aligned between the hospital, CBHO, and Peer Volunteers. The dynamics of the peer-to-peer relationship may be diluted by phone support, which can feel impersonal; as such, discharge transition programs of a similar nature could test a combined strategy of phone and in-person follow-up, perhaps with more frequent in-person meetings.

IV.A. Limitations

These results are from a small sample of Peer Volunteers who only provided support over a one-year timeframe; experiences of peers in other contexts may differ greatly. There is a risk to reporting bias as the training facilitators also analyzed the data, which may be mitigated by two additional coders who were not involved in the training and supervision of Peer Volunteers.

IV.B Adaptation and Continuation

In response to requests from the Peer Volunteers, the first author offered bimonthly group and individual supervisions at the conclusion of each match. These supervisions allowed Peer Volunteers to discuss arising issues and continue to connect training skills to practice in peer support. In supervision, Peer Volunteers expressed distress when a participant was nonresponsive and recommended a process of follow-up from the hospital's clinical outpatient team that was implemented as the program progressed. The partnership team also attempted to mitigate client concerns of drug stigma by discussing the program's harm reduction approach more explicitly with clients during the consent process, and to clarify the study's intent and approach with hospital staff.

Following an assessment of this pilot peer training program, informed by Canadian guidelines for implementing peer support[33], the hospital for people living with HIV/AIDS integrated peer support as a regular component of its inpatient acute and outpatient community departments in fall 2019. The inaugural peer training continued pilot components of harm reduction, active listening, congruent communication, and use of self while introducing new components of cultural competency and trans sensitivity to better address diversity in the hospital's client population. Simulation continued using scenarios relevant to a hospital environment and complex HIV care, with the addition of

peers having the opportunity, with client consent, to observe some peer support sessions for a more realistic sense of what the program may entail. Individual and group supervisions have continued for peers to share successes and discuss challenges. Based on pilot feedback, peer support is now primarily in-person with some phone contact. Finally, the program has broadened beyond a requirement for substance use conversation so that clients experiencing other issues (such as lack of housing or isolation) independent of drug use can still access peer support. The full training manual, including role play scenarios and these adaptations, can be found in supplementary file 2.

V. Conclusion

This article highlights a training curriculum designed for a peer support program in complex HIV healthcare. Peer Volunteers demonstrated use of key communication and support skills, while managing challenges concerning the nature of phone calls, boundaries, and transition from clinical to peer support. Practicing communication concepts through simulation was identified as particularly helpful. This study's findings, and detail on the pilot's adaptation to a core program, may be useful to other community-clinical partnerships in the provision of peer support. Specifically, the training manual and curriculum could be adopted and/or adapted for other sites and contexts. Greater partnership efforts to mitigate communication challenges and policy differences between community organizations and hospitals may also facilitate a successful peer support program of this nature.

VII. References

1. Genberg BL, Shangani S, Sabatino K, Rachlis B, Washira J, Braitstein, P, et al. Improving engagement in the HIV care cascase: a systematic review of interventions involving people living with HIV/AIDS as peers. AIDS Behav. 2016;20(10):2452-63.
2. Simoni JM, Nelson KM, Franks JC, Yard SS, Lehavot K. Are peer interventions for HIV efficacious? a systematic review. AIDS Behav. 2011;15(8):1589-95.
3. Latkin CA, Sherman S, Kowlton A. HIV prevention among drug users: outcome of a network-oriented peer outreach intervention. Health Psychol. 2003;22(4);332-9.
4. Van Tam V, Larsson M, Pharris A, Diedrichs B, Phuong Nguyen H, Thi Kim C. et al. Peer support and improved quality of life among persons living with HIV on antiretroviral treatment: a randomised controlled trial from north-eastern Vietnam. Health Qual Life Outcomes. 2012;10(53). https://doi.org/10.1186/1477-7525-10-53
5. Harris GE, Larsen D. HIV peer counseling and the development of hope: perspectives from peer counselors and peer counseling recipients. AIDS Patient Care STDs. 2007;21(11):843-860. https://doi.org/10.1089/apc.2006.0207
6. Naar-King S, Outlaw A, Green-Jones M, Wright K, Parsons JT. Motivational interviewing by peer outreach workers: a pilot randomized clinical trial to retain adolescents and young adults in HIV care. AIDS Care. 2009;21(7):868-73.
7. Omland LH, Ahlström MG, Obel N. Cohort profile update: the Danish HIV cohort study (DHCS). Int J Epidemiol. 2014;43:1769-1769e. https://doi.org/10.1093/ije/dyu153
8. Szadkowski L, Walmsley S, Burchell AN, Collins E, Rourke SB, Raboud J, et al. High retention in HIV care at a tertiary care centre in Toronto, Canada. AIDS Care. 2018;30(2):246-254. https://doi.org/10.1080/09540121.2017.1349278
9. Eaton AD, Chan Carusone S, Craig SL, Telegdi E, McCullagh JW, McClure D, et al. The ART of conversation: feasibility and acceptability of a pilot peer intervention to help transition complex HIV-positive people from hospital to community. BMJ Open. 2019;9:e026674. https://doi.org/10.1136/bmjopen-2018-026674

10. Lowthian JA, Lennox A, Curtis A, Wilson G, Rosewarne C, Smit V, et al. Hospitals and patients working in unity (HOW R U?): telephone peer support to improve older patients' quality of life after emergency department discharge in Melbourne, Australia – a multicentre prospective feasibility study. BMJ Open. 2018;8:e020321. https://doi.org/10.1136/bmjopen-2017-020321
11. Schaink AK, Kuluski K, Lyons RF, Fortin M, Jadad AR, Upshur R, et al. A scoping review and thematic classification of patient complexity: offering a unifying framework. J Comorb. 2012;2:1-9. https://doi.org/10.15256/joc.2012.2.15
12. Raja S, Teti M, Knauz R, Echenique M, Capistrant, B, Rubinstein S, et al. Implementing peer-based interventions in clinic-based settings: lessons from a multi-site HIV prevention with positives initiative. J HIV AIDS Soc Serv. 2008;7(1):7-26. https://doi.org/10.1080/15381500802093092
13. Lazarus L, Reza-Paul S, Pasha A, Jairam S, Ur Rahman SH, O'Neil J, et al. Exploring the role of community-based peer support in improving access to care and antiretroviral treatment for sex workers in Mysore, India. J HIV AIDS Soc Serv. 2012;11(2):152-168. https://doi.org/10.1080/15381501.2012.678132
14. UNAIDS. Political declaration on HIV and AIDS: on the fast track to accelerating the fight against HIV and to ending the AIDS epidemic by 2030. 2016 Jun 8. https://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf
15. MacLellan J, Surey J, Abubakar I, Stagg HR. Peer support workers in health: a qualitative metasynthesis of their experiences. PLoS ONE. 10(10):e0141122. https://doi.org/10.1371/journal.pone.0141122
16. Bateganya M, Amanyeiwe U, Roxo U, Dong M. Impact of support groups for people living HIV on clinical outcomes: a systematic review of the literature. J AIDS. 2015;68(suppl 3):S368-74. https://doi.org/10.1097/QAI.0000000000000519
17. AIDS United. Best practices for integrating peer navigators into HIV models of care. 2015. https://www.aidsunited.org/data/files/Site_18/PeerNav_v8.pdf

18. Kteily-Hawa R, Hari S, Pui-Hing Wong J, Chikermane V, Chambers LA. Development and implementation of peer leader training for community-based participatory sexual health research. Prog Commnity Health Partnersh. 2019;13(3):303-319. https://doi.org/10.1353/cpr.2019.0058
19. Kemp V, Henderson AR. Challenges faced by mental health peer support workers: Peer support from the peer supporter's point of view. Psychiatr Rehabil J. 2012;35(4):337-40. https://doi.org/10.2975/35.4.2012.337.340
20. Eaton AD, Craig SL, Wallace R. The intersecting cognitive and aging needs of HIV-positive older adults: Implications for social work practice. Soc Work Health Care. 2017;56(8);733-747. https://doi.org/10.1080/00981389.2017.1339759
21. Eaton AD, Walmsley SL, Craig SL, Rourke SB, Sota T, McCullagh JW, Fallon BA. Protocol for a pilot randomised controlled trial evaluating feasibility and acceptability of cognitive remediation group therapy compared with mutual aid group therapy for people ageing with HIV-associated neurocognitive disorder (HAND) in Toronto, Canada. BMJ Open. 2019;9;e033183. https://doi.org/10.1136/bmjopen-2019-033183
22. Eaton AD, Ibáñez-Carrasco F, Craig SL, Chan Carusone S, Montess M, Wells GA, Ginocchio GF. A blended learning curriculum for training peer researchers to conduct community-based participatory research. Action Learning: Res Prac. 2018;15(2);139-150. https://doi.org/10.1080/14767333.2018.1462143
23. Satir V, Gomori M, Gerber J, Banmen J. The Satir model: family therapy and beyond. 2nd ed. Palo Also: Science and Behavior Books; 2006.
24. Miller WR, Rollnick S. Motivational interviewing: Helping people change. 3rd ed. New York: Guilford Press; 2012.
25. Carter AL, Wilber C, Sahl R. Motivational interviewing techniques and the harm-reduction model in a short-term substance-abuse group for adolescents with psychiatric problems. Conn Med. 2005;69(9):519-524. PMID:16270788.
26. Eaton AD. Filmed simulation to train peer researchers in community-based participatory research. Soc Work Res. 2019;43(3):195-199. https://doi.org/10.1093/swr/svz011

27. Bogo M, Regehr C, Katz E, Logie C, Mylopoulos M. Developing a tool for assessing students' reflections on their practice. J Soc Work Educ. 2011;30(2):186-194. https://doi.org/10.1080/02615479.2011.540392
28. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77-101.
29. Closson K, McNeil R, McDougall P, Fernando S, Collins AB, Turje RB, Howard T, et al. Meaningful engagement of people living with HIV who use drugs: methodology for the design of a peer research associate (PRA) hiring model. Harm Reduct J. 2016;13(26):1-7. https://doi.org/10.1186/s12954-016-0116-z
30. Cully JA, Mignogna J, Stanley MA, Davila J, Wear J, Amico KR, Giordano TP. Development and pilot testing of a standardized training program for a patient-mentoring intervention to increase adherence to outpatient HIV care. AIDS Patient Care STDs. 2012;26(3):165-172. https://doi.org/10.1089/apc.2011.0248
31. Ryerson Espino SL, Precht A, Gonzalez M, Garcia I, Eastwood EA, Henderson T, et al. Implementing peer-based interventions in linkage and retention programs: successes and challenges. J HIV AIDS Soc Serv. 2015;*14*(4):417-431. https://doi.org/10.1080/15381501.2015.1081840
32. Scott A. Authenticity work: Mutuality and boundaries in peer support. Soc Ment Health. 2011;1(3):173-184. https://doi.org/10.1177/2156869311431101
33. CATIE. Practice guidelines in peer health navigation for people living with HIV. 2018. https://www.catie.ca/ga-pdf.php?file=sites/default/files/practice-guidelines-peer-nav-en-02082018.pdf